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No. 08-558

In the Supreme Court of the United States

ROBERT I. BOURSEAU, ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether petitioners were properly held liable under the "reverse false claims" provision of the False Claims Act, 31 U.S.C. 3729(a)(7), based on their submission of Medicare cost reports in which petitioners overstated their reimbursable costs and thereby reduced or concealed their obligation to repay the Medicare program for overpayments.

2. Whether the government sustained damages from petitioners' submission of Medicare cost reports that reduced or concealed petitioners' obligation to make immediate repayment of overpayments that petitioners had received from the Medicare program.

3. Whether the court of appeals correctly held that the district court's award of treble damages did not violate the Excessive Fines Clause of the Eighth Amendment or the Due Process Clause of the Fifth Amendment.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-33) is reported at 531 F.3d 1159. The opinion of the district court (Pet. App. 34-70) and the district court's order amending the opinion and judgment (Pet. App. 73-80) are not published in the Federal Supplement but are available at 2006 WL 2961105 and 2006 WL 3949169, respectively.

JURISDICTION

The judgment of the court of appeals was entered on July 14, 2008. A petition for rehearing was denied on August 19, 2008 (Pet. App. 83-84). The petition for a writ of certiorari was filed on October 23, 2008. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare program provides health insurance to persons 65 years of age and over, as well as to individuals receiving Social Security disability benefits. See 42 U.S.C. 1395c. Under Part A of the program, Medicae Act, 42 U.S.C. 1395c *et seq.*, Medicare beneficiaries are entitled to have payments made on their behalf to hospitals, including psychiatric hospitals, or to other Medicare providers as reimbursement for certain hospital care and related services. 42 U.S.C. 1395d (2000 & Supp. V 2005). Medicare reimburses providers for that portion of their reasonable cost of providing services that is incurred on behalf of Medicare beneficiaries. 42 U.S.C. 1395x(v)(1)(A). Fiscal intermediaries—private entities, generally insurance companies, acting pursuant to agreements with the Centers for Medicare and Medicaid Services—play a principal role in administering payments to Medicare providers. See 42 U.S.C. 1395h; 42 C.F.R. 421.3.[1]

In order to ensure adequate cash-flow to the providers, intermediaries make large estimated payments (called interim payments) to providers at frequent intervals, based on the provider's estimated treatment costs for Medicare patients, subject to reconciliation at the end of the cost reporting year. 42 U.S.C. 1395g(e) (2000 & Supp. V 2005); 42 C.F.R. 413.60, 413.64.[2] The regulatory scheme therefore specifically contemplates that

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[1] The fiscal intermediaries are now referred to as "Medicare administrative contractors." 42 U.S.C. 1395h(a) (Supp. V 2005).

[2] During the time period at issue in this case, psychiatric hospitals were reimbursed on a cost basis, see 42 C.F.R. Pt. 413, rather than under the prospective payment system, see 42 C.F.R. 412.400 *et seq.*, which was made applicable to psychiatric hospitals in 2005, see 42 C.F.R. 412.20(b).

providers will at times be overpaid and at other times underpaid. Each hospital annually submits to the appropriate intermediary a cost report that provides a final accounting of its actual costs for the year. 42 C.F.R. 413.20.

If the provider's cost report reflects that the Medicare program has overpaid the provider during the year, "a full refund is to be remitted with the report." United States Department of Health and Human Services, *Provider Reimbursement Manual* Pt. I, § 2409.1.A.2 (2005) (PRM).[3] If the cost report indicates that the provider was underpaid, the intermediary is directed to make a tentative retroactive adjustment, after correcting any obvious errors or inconsistencies in the cost report and offsetting any unrecovered overpayment. PRM § 2408.2; 42 C.F.R. 413.64(f)(2). After a more complete audit of the cost report, the intermediary issues a final notice of provider reimbursement (NPR) "reflecting the intermediary's determination of the total amount of reimbursement due the provider," which serves as "the basis for making the retroactive adjustment * * * to any program payments made to the provider during the period." 42 C.F.R. 405.1803.

When an intermediary believes either that a provider is involved in bankruptcy proceedings or that insolvency proceedings will shortly be instituted, the intermediary is directed to take steps to prevent overpayments to the provider. In such circumstances, "any payments to the provider will be adjusted by the intermediary, notwith-

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[3] The PRM "is an extensive set of informal interpretative guidelines and policies published [by the agency which administers the Medicare program] to assist intermediaries and providers in applying the reasonable cost reimbursement principles." *Providence Hosp.* v. *Shalala*, 52 F.3d 213, 218 (9th Cir. 1995).

standing any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made." 42 C.F.R. 413.64(i). The PRM similarly directs intermediaries not to make additional payments to potentially insolvent providers as part of a tentative initial adjustment based on the provider's cost report, but instead to wait until a final NPR is issued. PRM § 2408.2.

2. The United States filed this action against petitioners under the False Claims Act (FCA), 31 U.S.C. 3729 *et seq.*, and for unjust enrichment and common law fraud. The government alleged that petitioners had defrauded the Medicare program while operating Bayview Hospital and Mental Health Systems (Bayview), a California psychiatric hospital owned and operated by petitioners through their partnership California Psychiatric Management Services (CPMS). The government contended that petitioners had submitted various cost reports seeking reimbursement for costs that either were not actually incurred or were not eligible for Medicare reimbursement.

Under the FCA, persons who commit a variety of acts involving false claims against the federal government are liable to the United States for civil penalties "plus 3 times the amount of damages which the Government sustains because of the act of that person." 31 U.S.C. 3729(a). Section 3729(a)(7), commonly known as the FCA's "reverse false claims" provision, imposes liability upon any person who "knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). The district court held that peti-

tioners had violated Section 3729(a)(7) by submitting their 1997, 1998, and 1999 cost reports, which decreased the amount CPMS owed Medicare by $5,219,195. Pet. App. 59-67; *id.* at 75. In particular, the court found that CPMS had fraudulently included in its cost reports interest ostensibly charged to CPMS by one of its creditors, which was never paid by CPMS and which was unrelated to the treatment of Medicare patients at Bayview; bankruptcy fees unrelated to care for Medicare patients; a fictitious rent expense; costs associated with space that was not used for patient care; and management fees paid to a related entity that provided no management services. *Id.* at 42-52. Pursuant to 31 U.S.C. 3729(a), the district court awarded the United States treble damages in the amount of $15,657,585, as well as $31,000 in civil penalties. Pet. App. 75.

3. The court of appeals affirmed. Pet. App. 1-33. Like the district court, the court of appeals concluded that the government had proved all the elements necessary to establish liability under the FCA's reverse false claims provision—*i.e.*, that petitioners had (1) knowingly (2) made, used, or caused to be made or used a record or statement that was (3) materially (4) false, (5) with the purpose to conceal, avoid, or decrease an obligation to pay money to the government. *Id.* at 10-27.

The court of appeals rejected petitioners' argument that the false costs claimed on the cost reports were not material to the implementation of the Medicare program. Pet. App. 25-27. Applying the standard established by this Court in *Neder* v. *United States*, 527 U.S. 1 (1999), the court of appeals concluded that the false statements contained in CPMS's cost reports "were material because they had the potential effect, or natural tendency, to decrease the amount CPMS owed Medicare

in overpayments." Pet. App. 27; see *id.* at 26 (quoting *Neder*, 527 U.S. at 16 ("[i]n general, a false statement is material if it has 'a natural tendency to influence, or [is] capable of influencing, the decision of the decision-making body to which it was addressed.") (brackets in original).

The court of appeals also rejected petitioners' contention that CPMS's fraudulent cost reports did not damage the United States. Pet. App. 27-31. The court explained that "[d]amages for a reverse false claim consist of the difference between what the defendant should have paid the government and what the defendant actually paid the government." *Id.* at 30. The court concluded that petitioners "had a legal obligation to pay the government money at the time they submitted the cost reports," *id.* at 23, and that "the difference between what CPMS should have repaid the government and what it did repay the government [was] $5,219,195," *id.* at 30. The court rejected petitioners' argument that their precarious financial position relieved them of any obligation to repay the overpayment. *Id.* at 27-28. The court explained that, under the relevant Medicare regulation, special care should be taken to *prevent* overpayments to potentially insolvent providers. *Id.* at 28 (citing 42 C.F.R. 413.64(i)).

The court of appeals rejected petitioners' argument that the district court's award of treble damages plus civil penalties violated petitioners' constitutional rights. Pet. App. 31-33. Examining the four relevant factors identified in *United States* v. *Mackby*, 339 F.3d 1013, 1016 (9th Cir. 2003), cert. denied, 541 U.S. 936 (2004), the court concluded that (1) making false claims to the government was a serious offense, (2) the government had sustained harm to its fiscal interests and to the in-

tegrity of the Medicare program, and (3) petitioners fell squarely within the class of persons targeted by the FCA. Pet. App. 33. The court found that one *Mackby* factor—the fact that the district court had imposed the maximum penalty permitted under the FCA—favored petitioners. *Id.* at 32. The court of appeals concluded, however, that nothing prohibited the district court from awarding the maximum amount, and that when all four factors were considered in the aggregate, the award was not grossly disproportionate to the gravity of petitioners' offenses. *Id.* at 33.

ARGUMENT

The court of appeals' decision is correct and does not conflict with any decision of this Court or of any other court of appeals. Further review is not warranted.

1. Petitioners contend (Pet. 14-18) that the false statements on their cost reports were not "material" to the government's administration of the Medicare program, and that the court of appeals' analysis of materiality conflicts with decisions of the Eighth Circuit. Contrary to petitioners' contention, the evidence in this case satisfied both the "natural tendency" test adopted by the Third, Fourth, Sixth, Seventh, Ninth, and Tenth Circuits, and the "outcome materiality test" that petitioners contend has been adopted by the Eighth Circuit.

a. Although the FCA does not contain a distinct materiality *element*, the submission of a false statement to a government official does not, in and of itself, violate the statute. The most commonly-invoked provision of the FCA imposes liability upon a person who "knowingly presents * * * [to the federal government] a false or fraudulent claim for payment or approval." 31 U.S.C. 3729(a)(1). When a defendant's asserted liability under

Section 3729(a)(1) is premised on a false statement made on or in connection with a claim form, the false statement will not render the "claim" itself "false or fraudulent" unless the statement is potentially relevant to the government's payment decision.

The FCA provision at issue in this case imposes liability on one who "knowingly makes [or] uses * * * a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). Under Section 3729(a)(7), a false statement that has no potential bearing on the government's collection of funds is not appropriately characterized as being made or used "to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." Thus, while the FCA contains no separate materiality element, the pertinent liability provisions require proof of a logical connection, substantively analogous to a requirement of "materiality" as that term has traditionally been understood, between a defendant's false statement and the government's payment or collection of money.

b. Petitioners contend (Pet. 11, 15) that, in order to establish that a defendant's misrepresentation was material under Section 3729(a)(7), the United States must prove that the defendant's actions actually deprived the government of money it was lawfully due. That argument lacks merit for at least three reasons.

i. In *Neder* v. *United States*, 527 U.S. 1 (1999), this Court stated that "actionable 'fraud' had a well-settled meaning at common law," and that "the well-settled meaning of 'fraud' required a misrepresentation or concealment of *material* fact." *Id.* at 22. Consistent with that traditional understanding, the Court construed the federal mail fraud, wire fraud, and bank fraud statutes

to contain a materiality requirement. *Id.* at 20-25. The Court further explained that, "[i]n general, a false statement is material if it has a natural tendency to influence, or is capable of influencing, the decision of the decision-making body to which it was addressed." *Id.* at 16 (brackets, internal quotation marks, and citation omitted).

The Court in *Neder* made clear, however, that a conviction under those federal fraud statutes does not require proof that the victim actually relied on the false representations or was damaged by the defendant's misconduct. See 527 U.S. at 24-25. The Court treated those elements of common-law fraud as separate from the requirement that a defendant's misrepresentations be material. See *ibid.* The Court held that "the elements of reliance and damage would clearly be inconsistent with the statutes Congress enacted" because those statutes refer to "'scheme[s] to defraud,' rather than the completed fraud." *Id.* at 25. In light of the *Neder* Court's holding that the government may prove materiality without proving reliance or damages, there is no basis for petitioners' contention that a misrepresentation is necessarily immaterial if it did not ultimately deprive the government of money it was lawfully due.

ii. The text of the FCA also does not support petitioners' contention that liability under the Act depends on proof of an actual effect on the government's payment or recoupment decision. Under 31 U.S.C. 3729(a)(1), any person who "knowingly presents" a "false or fraudulent claim" to the federal government is liable for damages and civil penalties. Because Section 3729(a)(1) attaches liability upon *presentment* of a false or fraudulent claim, rather than *actual payment* on that claim, the question whether the provision was violated in a particular case

should be resolved based on the facts as they existed at the time of presentment. Whether a particular false statement would have the "natural tendency" to affect the government's payment decision can be determined without reference to events (such as the government's actual disposition of the claim) that postdate the claim's submission. Thus, just as Congress's decision to prohibit certain "scheme[s] to defraud" was held to reflect a decision not to require proof of reliance and damages under the federal fraud statutes at issue in *Neder*, see 527 U.S. at 24-25, Congress's focus on the "present-[ment]" of false claims under 31 U.S.C. 3729(a)(1) manifests a similar intent.

Similarly, the reverse false claims provision, Section 3729(a)(7), focuses on the "mak[ing]" or "use[]" of false records or statements. Although Section 3729(a)(7) imposes the additional requirement that the false record or statement be made or used "to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government," that language is most sensibly construed simply to require a logical connection between the false record or statement and a defendant's obligation to pay money or property to the United States. Section 3729(a)(7) requires knowing concealment or avoidance, but it does not require that the defendant's misconduct culminate in any particular result. See *United States ex rel. A+ Homecare, Inc.* v. *Medshares Mgmt. Group, Inc.*, 400 F.3d 428, 445-446 (6th Cir.), cert. denied, 546 U.S. 1063 (2005). And there is no reason to suppose that Congress, having focused on the *potential* (rather than the actual) effect of a claimant's conduct in 31 U.S.C. 3729(a)(1), would require proof of an actual impact on the federal fisc in the later-enacted Section 3729(a)(7). To the contrary, the legislative history

strongly indicates that the two provisions should be construed *in pari materia*. See S. Rep. No. 345, 99th Cong., 2d Sess. 18 (1986) (Section 3729(a)(7) "provide[s] that an individual who makes a material misrepresentation to avoid paying money owed the Government would be equally liable under the Act as if he had submitted a false claim to receive money."); H.R. Rep. No. 660, 99th Cong., 2d Sess. 20 (1986) (Section 3729(a)(7) reflects the view "that there is no reason to treat a false claim filed against the Government to fraudulently reduce an obligation owed to the Government differently from one filed for the purpose of fraudulently obtaining money.").

iii. "[E]valuating materiality based on the potential effect rather than actual result is more consistent with the underlying purpose of the FCA." *A+ Homecare*, 400 F.3d at 446. This Court "has broadly interpreted the statute to cover 'all fraudulent *attempts* to cause the Government to pay out sums of money.'" *Ibid.* (quoting *United States* v. *Neifert-White Co.*, 390 U.S. 228, 233 (1968)). The logical implication of petitioners' theory, however, is that a claimant who seeks to obtain government funds through fraud will escape FCA liability altogether if the government detects the misrepresentation before payment is made and thereby avoids an actual financial loss. Creation of such a loophole would subvert Congress's intent to deal comprehensively with efforts to obtain federal money or property by dishonest means.

c. The court of appeals concluded that the false statements on petitioners' cost reports "were material because they had the potential effect, or natural tendency, to decrease the amount CPMS owed Medicare in overpayments, despite the fact that cost reports were never audited." Pet. App. 27. That conclusion is consistent with the Sixth Circuit's ruling in *A+ Homecare*, the

only other appellate decision directly on point. As in this case, the defendant in *A+ Homecare* included a false cost in its cost report, but the intermediary delayed completing its audits pending the outcome of the fraud investigation. *A+ Homecare*, 400 F.3d at 456.[4] The Sixth Circuit concluded that, under Section 3729(a)(7), a court's determination of materiality should be "based on the potential effect rather than actual result" of the defendant's false statement, *id.* at 446, and that the intermediary's failure to complete the audit was "irrelevant in this case * * * because the mere act of placing the false accrual on the Cost Report is sufficient to find [defendant] liable under the FCA," *id.* at 446 n.13. The same analysis applies here.

d. The Ninth Circuit's "natural tendency" test is consistent with the standard for FCA liability adopted by five other circuits. Those courts have recognized that, so long as the defendant's false statements reasonably *could have* influenced the government's payment or collection of money, the FCA does not require proof of any actual fiscal impact. See *United States* v. *Rogan*, 517 F.3d 449, 452 (7th Cir. 2008); *United States ex rel. Bahrani* v. *Conagra, Inc.*, 465 F.3d 1189, 1204 (10th Cir. 2006), cert. denied, 128 S. Ct. 388 (2007); *A+ Homecare*,

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[4] Petitioners assert that their fraudulent cost reports were not audited because the fiscal intermediary knew of CPMS's precarious financial situation and the PRM precludes any action with respect to the cost reports of a provider suspected of insolvency. Pet. 6, 8, 17, 22-23. As discussed below, petitioners misunderstand the pertinent regulatory and PRM provisions. See p. 17, *infra*. Moreover, petitioners are incorrect as a factual matter. The trial record disclosed that the intermediary discontinued its audit because, after receiving an allegation of fraud, the Medicare program initiated an investigation culminating in this FCA action by the United States. See C.A. E.R. 242-243; C.A. Supp. E.R. 25-26.

400 F.3d at 446; *United States ex rel. Harrison* v. *Westinghouse Savannah River Co.*, 352 F.3d 908, 913, 916-917 (4th Cir. 2003); *United States ex rel. Cantekin* v. *University of Pittsburgh*, 192 F.3d 402, 415-416 (3d Cir. 1999), cert. denied, 531 U.S. 880 (2000).

Petitioners contend (Pet. 11, 15) that the court of appeals' decision in this case conflicts with the Eighth Circuit's decision in *Costner* v. *URS Consultants, Inc.*, 153 F.3d 667, 677 (1998) (*Costner I*). Petitioners construe the decision in *Costner I* as requiring the government to show "that the defendants' actions actually caused the United States to pay out money it was not obligated to pay or actually deprived the United States of money it was lawfully due." Pet. 11. The Ninth Circuit in this case likewise understood the Eighth Circuit to have applied an "outcome materiality test," which the Ninth Circuit regarded as inconsistent with its own "natural tendency" standard. Pet. App. 26. For two reasons, any tension between the legal standards adopted by the Ninth and Eighth Circuits in this area provides no basis for further review here.

i. More recent decisions of the Eighth Circuit indicate that the court has not yet settled on a precise standard for defining the circumstances under which a defendant's misrepresentations will give rise to FCA liability. In *United States ex rel. Costner* v. *United States*, 317 F.3d 883, cert. denied, 540 U.S. 875 (2003) (*Costner II*), the Eighth Circuit characterized its earlier decision in *Rabushka ex rel. United States* v. *Crane Co.*, 122 F.3d 559, 563 (1997), cert. denied, 523 U.S. 1040 (1998), as merely "*suggest*[*ing*] that outcome materiality is the proper standard," and similarly regarded *Costner I* as only "*impl*[*ying*] a materiality standard stricter than mere relevancy." *Costner II*, 317 F.3d at 887 (emphases

added). The court in *Costner II* concluded that it "need not decide the precise contours of the materiality requirement" because there was no evidence to show that the defendant's alleged false statement "was even relevant to [the agency's] payment decision." *Ibid.*

The Eighth Circuit subsequently reiterated that *Costner II* had "confirmed that a showing of materiality is implicit in the FCA, though we did not define 'the precise contours' of this requirement." *Hays* v. *Hoffman*, 325 F.3d 982, 992, cert. denied, 540 U.S. 877 (2003) (quoting *Costner II*, 317 F.3d at 887). In *Hays*, the defendants conceded in their reply brief "that the false claims were material if they were capable of influencing the government's payment decision." *Ibid.* (internal quotation marks and citation omitted). The Eighth Circuit noted that "[t]he district court's instructions included that concept in a definition of materiality," and the court further observed that the defendant's false representations were "capable of influencing, and did in fact influence, the government's Medicaid reimbursement decisions." *Ibid.* The court of appeals concluded that "the instructions 'taken as a whole and viewed in light of the evidence and the applicable law, fairly and adequately submitted the issues in the case to the jury.'" *Ibid.* (quoting *Gray* v. *Bicknell*, 86 F.3d 1472, 1485 (8th Cir. 1996)). *Costner II* and *Hays* suggest that the Eighth Circuit has thus far declined to choose between the "natural tendency" test employed by the court of appeals in this case, and the more demanding "outcome materiality" standard advocated by petitioners. Because the Eighth Circuit has not defined the "precise contours" (*Costner II*, 317 F.3d at 887) of its materiality standard and has not unequivocally chosen the standard petitioners urge, any tension between the existing Ninth

and Eighth Circuit precedents does not warrant this Court's review.

ii. Even if a fully developed circuit conflict did exist, this case would be an unsuitable vehicle for resolving it, because there is no reason to suppose that petitioners would have escaped FCA liability under the "outcome materiality" standard that petitioners advocate. The FCA's reverse false claims provision imposes liability on any person who knowingly uses "a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). As the court of appeals correctly explained, petitioners "had a legal obligation to pay the government money at the time they submitted the cost reports." Pet. App. 23; see *id.* at 58 ("Hospitals are required to remit a full refund of overpayments to Medicare at the time they file their cost reports."); see also PRM § 2409.1.A.2 ("When the provider files a cost report indicating that an overpayment has occurred a full refund is to be remitted with the report."). Petitioners' fraudulent conduct therefore resulted in a different "outcome"—*i.e.*, a failure to repay the Medicare program the amount that an accurate cost report would have identified as due and owing—than would have occurred if petitioners had complied with their legal obligations. Petitioners do not contend that any decision of the Eighth Circuit has held Section 3729(a)(7) to be inapplicable in circumstances like these.

This Court recently denied a petition for a writ of certiorari regarding the FCA's materiality standard from the Sixth Circuit's decision in *A+ Homecare*, in which the court of appeals upheld an FCA judgment in a Medicare reimbursement case substantially similar to this one. See *Winters* v. *United States ex rel. A+*

Homecare, Inc., 546 U.S. 1063 (2005). There is no reason for a different result in this case.

2. The court of appeals correctly concluded (Pet. App. 27-30) that petitioners' false cost reports damaged the United States. Contrary to petitioners' contention (Pet. 17-19), that holding does not conflict with the decisions of any other court of appeals.

a. Petitioners contend that the government could not prove damages in this case because it could not show that it "relied on a false claim or representation in making a payment decision." Pet. 17 (citing *United States ex rel. Schwedt* v. *Planning Research Corp.*, 59 F.3d 196, 199-200 (D.C. Cir. 1995), cert. denied, 516 U.S. 1068 (1996)). Unlike *Schwedt*, however, this case involves the FCA's reverse false claims provision, which prohibits the making or use of "a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." 31 U.S.C. 3729(a)(7). Both in general and in this case, the harm that can naturally be expected to result from a violation of Section 3729(a)(7) is a failure by the government to *receive* funds owed to the United States, rather than the *disbursement* of federal money to persons who are not entitled to receive it.

There is consequently no basis for petitioners' contention (Pet. 17), in a suit filed under Section 3729(a)(7), that the government's ability to prove damages depended on evidence that it "relied" on petitioners' false statements in "making a payment decision." As explained above (see p. 15, *supra*), the court of appeals correctly held that petitioners "had a legal obligation to pay the government money at the time they submitted the cost reports" showing an overpayment by the Medicare program. Pet. App. 23; see *id.* at 58; PRM § 2409.1.A.2.

The government therefore was damaged when petitioners submitted cost reports that fraudulently reduced the amount that CPMS was required to repay the government.

Petitioners contend that immediate reimbursement of any overpayment is required "*unless* the provider was in bankruptcy or insolvent, which was the case here." Pet. 22; see Pet. 6 (contending that, under PRM § 2408.2, "no action is taken on a cost report submitted by a provider when the provider is potentially insolvent or is the subject of bankruptcy proceedings"). The court of appeals correctly rejected that reading of the pertinent regulatory and PRM provisions. See Pet. App. 27-28. Rather than relieving potentially insolvent providers of any obligation to repay overpayments, the provisions at issue protect *the Medicare program* by directing intermediaries to take particular care to avoid overpayments to such providers. The applicable Medicare regulation provides that, "notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments," when an intermediary believes that a provider may be insolvent, "any payments to the provider will be adjusted by the intermediary * * * to a level necessary to insure that no overpayment to the provider is made." 42 C.F.R. 413.64(i). The PRM similarly states that the intermediary should not make a tentative adjustment payment to a potentially insolvent provider on the basis of the provider's unaudited cost report. PRM § 2408.2. In any event, to the extent that petitioners' disagreement with the court of appeals' damages analysis turns on the proper interpretation of the Medicare regulations and the PRM, petitioners do not allege a conflict in the circuits on that issue, nor do they identify any other reason that the dis-

puted question of Medicare law would warrant this Court's review.

b. Petitioners also contend (Pet. 23) that the United States was not damaged by petitioners' fraud because the intermediary took no action to collect even the fraudulently reduced amounts that CPMS's cost reports acknowledged had been overpaid by the Medicare program. That assertion is factually inaccurate. By filing a claim in the bankruptcy proceedings, the government has attempted to collect the overpayments that were acknowledged on CPMS's cost reports but that CPMS did not immediately remit. Pet. App. 35.

Even if the government had forgone any effort to collect the smaller amount of CPMS's *acknowledged* debt to the Medicare program, the United States would still have been damaged by petitioners' fraudulent understatement of the sum owed to the United States and their attendant failure to pay that additional debt. In arguing that the government was not harmed by their fraudulent conduct, petitioners appear to contend (see Pet. 23) that, because the intermediary made no effort to collect the smaller amount that petitioners conceded was owed, it would likewise have ignored the much larger debt that an accurate cost report would have identified if petitioners had acknowledged the existence of the larger debt but had failed to pay it when the cost report was submitted. That contention is both factually speculative and legally flawed. To determine whether (and how greatly) the government was harmed by petitioners' fraudulent understatement of CPMS's debt to the United States, the courts below correctly took as their point of comparison the money that the government would have obtained if petitioners had fully complied with their legal obligations—*i.e.*, if they had ac-

knowledged the additional debt *and had promptly paid it* in accordance with applicable Medicare rules.

c. Petitioners contend (Pet. 17, 23-24) that the court of appeals' damages analysis conflicts with that of the D.C. Circuit in *Schwedt*. As noted above, however, the court in *Schwedt* did not construe the FCA's reverse false claim provision, but rather addressed the requirements for showing damages in an FCA action for submitting "a false or fraudulent claim for payment or approval," 31 U.S.C. 3729(a)(1), or submitting "a false record or statement to get a false or fraudulent claim paid or approved," 31 U.S.C. 3729(a)(2). See *Schwedt*, 59 F.3d at 199. In that context, the court held that reliance on the false record, statement, or claim in making or approving a payment was necessary to prove damages. *Id.* at 200.

A violation of Section 3729(a)(7), by contrast, injures the United States whenever the wrongdoer fails to pay the government the fraudulently concealed debt, even though no federal official relies on the false statement in making any payment decision.[5] To the extent petitioners rely on *Schwedt* for the broader proposition that damages are allowable under the FCA only if they were proximately caused by the defendant's fraud, 59 F.3d at 200, the decision of the court of appeals is not to the contrary. Rather, the court determined that $5,219,195 was "the difference between what CPMS should have repaid the government and what it did repay the government"

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[5] The Fifth and Third Circuit decisions on which the court in *Schwedt* relied, see 59 F.3d at 200 (citing *United States* v. *Hibbs*, 568 F.2d 347 (3d Cir. 1977), and *United States* v. *Miller*, 645 F.2d 473 (5th Cir. 1981)), are similarly distinguishable because neither involved reverse false claims.

and further confirmed that "none of the disputed costs was allowable." Pet. App. 30-31.

3. The court of appeals correctly rejected petitioners' constitutional challenges to the treble damages award against them, see Pet. App. 31-33, and that holding does not conflict with the decision of any other court of appeals.

a. Petitioners contend (Pet. 20) that the court of appeals adopted a categorical rule that "a District court is prohibited from reducing a judgment below statutory limits based on the excessive fines clause." The court of appeals issued no such holding. Rather, the court applied its earlier decision in *United States* v. *Mackby*, 339 F.3d 1013, 1016 (9th Cir. 2003), cert. denied, 541 U.S. 936 (2004), which, consistent with this Court's decision in *United States* v. *Bajakajian*, 524 U.S. 321 (1998), concluded that an award violates the Excessive Fines Clause if it is grossly disproportionate to the gravity of the defendant's conduct, *Mackby*, 339 F.2d at 1016. See Pet. App. 32. The court in *Mackby* identified four factors to be considered in determining whether an award is grossly disproportionate: (1) the severity of the offense and its relation to other criminal activity; (2) the maximum penalty faced; (3) the harm caused; and (4) whether the defendant falls within a class of persons targeted by the applicable law. 339 F.3d at 1016-1017.

In this case, the court of appeals concluded that the first, third, and fourth *Mackby* factors favored the United States because (1) making false claims to the government is a serious offense, (2) the government sustained harm to its fiscal interests and to the integrity of the Medicare program, and (3) petitioners fell squarely within the class of people targeted by the FCA. Pet. App. 33. The court found that the second *Mackby* factor

favored petitioners "because the district court imposed treble damages and the maximum amount of allowable civil penalties." *Id.* at 32. Looking at all four factors together, the court of appeals concluded that the award was not grossly disproportionate to the gravity of petitioners' offenses. *Id.* at 33.

That conclusion was correct. Petitioners caused the making of false statements and false reports in order to reduce by more than $5 million the amount CFMS owed Medicare, and that amount has never been repaid. Based on that conduct, the district court imposed judgment against petitioners for $15,657,585 in treble damages and for a civil penalty of $31,000. Pet. App. 75. That award is no more excessive than the treble damages awarded against the defendant in *A+ Homecare*, 400 F.3d at 454, or the award of nearly 12 times the government's damages upheld in *Mackby*, 339 F.3d at 1015-1019.

b. Petitioners' challenge under the Fifth Amendment's Due Process Clause (Pet. 20-21) also lacks merit. As the district court noted, an FCA damages award is not the product of a jury verdict and does not have the potentially arbitrary quality of a classic punitive damages award. Pet. App. 78-79. Moreover, treble damages are well within the suggestion in *State Farm Mutual Automobile Insurance Co.* v. *Campbell*, 538 U.S. 408, 425 (2003), that single-digit multiples of compensatory damages do not run afoul of the Due Process Clause. See Pet. App. 79 n. 3. And as this Court recognized in *Cook County* v. *United States ex rel. Chandler*, 538 U.S. 119 (2003), some part of an FCA award "beyond the amount of the fraud is usually 'necessary to compensate the Government completely for the costs, delays, and inconveniences occasioned by fraudulent claims,'" *id.* at

130 (quoting *United States* v. *Bornstein*, 423 U.S. 303, 315 (1976)), and for the unavailability of prejudgment interest and other consequential damages, *id.* at 131. The Court in *Chandler* explained that, while treble damages under the FCA "will exceed full compensation in a good many cases," *ibid.*, they are significantly different from "classic punitive damages," *id.* at 132.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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